Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AHMED KHALIFA MD

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-11-1040-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
NOVEMBER 24, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier failed to reimburse claim for the full amount even after reconsideration was sent."

Amount in Dispute: $28.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No additional payments are due. 'The provider's contract termed 09/01/2010. The DOS are within the contracted range. The provider contracted rates are for 70% of billed charges or PPO MAX fee schedule. There is not exclusion for DD visits'."

Response Submitted By: Pappas & Suchma, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 9, 2010	CPT Code 99204 –New Patient Office Visit	$0.68	$0.00
	CPT Code 95861 – Needle EMG	$0.54	$0.00
	CPT Code 95900(X4) – Nerve Conduction Study	$0.96	$0.03
	CPT Code 95904(X4) – Nerve Conduction Study	$0.84	$0.00
	HCPCS Code A4556 - Electrodes	$25.00	$0.00
TOTAL		$28.02	$0.03

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.4, effective July 27, 2008, requires the insurance carrier to notify providers of contractual agreements for informal and voluntary networks.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97-Payment is included in the allowance for another service/procedure.
   - 45-Charges exceed your contracted/legislated fee arrangement.
   - BL-Any reduction is in accordance with the Focus Beech Street Contract.
   - BL-This bill is a reconsideration of a previously reviewed bill.

Issues

1. Does a contractual agreement issue exist in this dispute?
2. Is the value of HCPCS code A4556 included in the value of another service rendered on the disputed date?
3. Is the requestor entitled to additional reimbursement for CPT codes 99204, 95861, 95900 and 95904?

Findings

1. According to the explanation of benefits, the respondent paid for the disputed services based upon reason code "45." No documentation was submitted to support this denial; therefore, the disputed services will be reviewed per applicable Division rules and guidelines.

2. According to the explanation of benefits, the respondent denied reimbursement for HCPCS Code A4556 based upon reason code "97."

   HCPCS Code A4556 is defined as "Electrodes (e.g., apnea monitor), per pair."

   28 Texas Administrative Code §134.203(a)(5), states "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   Per Medicare policy, if HCPCS codes A4556 is incidental to the physician service, it is not separately payable. A review of the submitted documentation does not support a separate service. As a result, reimbursement is not recommended.

3. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2010 DWC conversion factor for this service is 54.32.

   The Medicare Conversion Factor is 36.8729

   Review of Box 32 on the CMS-1500 the services were rendered in Houston, Texas; therefore, the Medicare participating amount is based upon the locality of "Houston, Texas".

Code	Medicare Participating Amount	MAR	Amount Paid	Amount Due
99204	$158.47	$233.45	$233.46	$0.00
95861	$123.95	$182.59	$182.59	$0.00
95900 (X4)	$55.58/ea	$327.51	$327.48	$0.03
95904 (X4)	$48.91/ea	$288.21	$288.24	$0.00

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $0.03.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $0.03 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	04/24/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.